EXHIBIT 88

AmerisourceBergen

Retail Pharmacy Questionnaire

Form will not be processed unless all questions are completed

Office Use Only

Name of BDM or Account Manager:_____

Phone of BMD or Account Manager: _____

Servicing Distributions Center(s) _____

This questionnaire is to be completed by the Owner and Business Development Manager during an on-site visit

1. Pharmacy Name: _____
   a. ABC Account number (Legacy)_____
   b. Pharmacy's dba (doing business as), if any _____
   c. Has the pharmacy ever operated under a different name?
      Yes____ No____ If yes, provide the Name:
      _____
   d. Will ABC be this customer's primary wholesaler? Yes____ No ____
   e. Has this customer signed a Prime Vendor agreement? Yes___ No___
   f. Does this customer have a PVA or equivalent with any other wholesaler?
      Yes___ No___ If yes, name _____

2. Pharmacy Address: _____
   a. Street:
   b. City_____
   c. State_____
   d. Zip_____

3. Pharmacy Phone Number: _____ Fax Number: _____

4. Pharmacy Email Address: _____

5. Check one:
   ☐ Start-up business. Other suppliers _____
   ☐ Existing business adding or changing suppliers. _____
   Estimated monthly dollar volume _____
   Identify any secondary suppliers customer intends to utilize._____
   Identify prior suppliers _____
   Has a supplier ever suspended or ceased controlled substance sales to the pharmacy? ____Yes ____No
   If yes, why_____
   ☐ Existing ABC Customer. Account # _____

6. Name of pharmacist –in –charge (PIC) as it appears on the license
   _____

7. PIC's state license number: _____

8. Has the PIC ever been sanctioned/disciplined in any state(s) where they are or have been licensed?
   Yes____ No____ If Yes, give details (when, why, etc.)
   _____
   _____
   _____

9. Is this pharmacy affiliated with any other pharmacy?
   Yes____ No____ If yes, provide the following:

   Name: _____
   Address: _____
   Phone Number: _____Fax Number:_____

   Note: If there are additional affiliates please attach an additional sheet with the information

10. Ownership type: Check one
    a. Sole Proprietor ____ Corporation_____ Partnership_____ Other_____(describe)
    b. If corporation, provide name of CEO_____

11. Owner(s) name: _____

12. Owner State of Residence: _____

13. Owner Phone Number: _____ Fax Number: _____

14. Owner Email Address: _____

15. Number of years owner has operated pharmacy _____

16. Is the Owner a licensed pharmacist?
    Yes____ No____

17. Pharmacy DEA registration #: _____

18. State BOP license #_____

19. What is the pharmacy's Self-Certification number which is required to sell pseudoephedrine products?
    _____ (refer to: http://www.deadiversion.usdoj.gov/meth/index.html#sales)

20. Has the Pharmacy ever had a DEA registration or State license/registration suspended or revoked? Yes____ No____
    If so, give details (when, why, etc.)
    _____
    _____

21. Has the Owner, family member, or any employee of the pharmacy ever had a DEA registration or State license/registration suspended or revoked?
    Yes____ No____ If so, give details (when, why, etc.)
    _____
    _____

22. Does the pharmacy have any other licensure/registration (wholesale, repackager, etc...)?
    Yes____ No____ If so, provide copies.

23. Check the following manners of receiving business and provide what percentage of the total business it comprises:

Walk-In	Yes____	No____	_____%
Phone	Yes____	No____	_____%
Fax	Yes____	No____	_____%
Internet/Mail Order/E-Scribe	Yes____	No____	_____%

24. Which state(s) does the pharmacy ship into (if any)? _____
    _____

25. Is the pharmacy licensed for sales in all states it distributes to?
Yes____ No____

26. Are all prescriptions written by physicians located in the state in which the patient resides?
Yes____ No____

27. Does the pharmacy have written policies and procedures regarding the filling of prescriptions?
_____ Yes _____ No If yes, information may be required to be produced upon request
a. How many prescriptions are filled daily_____; monthly_____?
b. Percentage of prescriptions that are controlled substances_____%
c. Verification process _____
_____
d. Does the pharmacy use the State Rx monitoring program? ____Yes ____No ____ N/A
e. Does the pharmacy verify the physician's state license and/or DEA registration? ___ Yes ___ No
f. Does the pharmacy engage in discussions with prescribing physicians? ___ Yes ____ No If yes, how documented? _____
g. What is the pharmacy's procedure for reporting fraudulent Rx's?
_____

28. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA/OTC	Yes____	No____ _____% of total purchases
Non-Controlled Rx	Yes____	No____ _____% of total purchases
Controlled Substances	Yes____	No____ _____% of total purchases
Listed Chemicals	Yes____	No____ _____% of total purchases

29. Anticipated or actual usage of certain controlled substances:

Item	Monthly Usage Values in # of tabs	Average Tablets per Prescription	Average Days Supply per Prescription
Oxycodone Products			
Oxycodone 30 mg IR			
Hydrocodone			
Alprazolam			
Carisoprodol			

List top 5 prescribing physicians ranked by volume of prescriptions for OX or HY, whichever is greater:

Name	DEA Registration	# Prescriptions Monthly	% to overall prescription volume

30. Does the pharmacy have a web site?
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon establishing a web site.

31. Will the pharmacy download and fill prescriptions on a per prescription fee basis from a website for dispensing?

    Yes____ No____ If yes, provide web address(es):

    _____

32. Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:

Private Insurance	Yes____	No_____% of revenue
Medicare/Medicaid	Yes____	No_____% of revenue
Cash	Yes____	No_____% of revenue
Other	Yes____	No_____% of revenue

    If other, provide details _____

33. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).

OTHER COMMENTS/OBSERVATIONS

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Retail Pharmacy Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

OWNER:
Name of Entity/Person
By: _____

_____
Name:

_____
Title:

_____
Date:

I, as the authorized AmerisourceBergen representative, declare that I have reviewed this Retail Pharmacy Questionnaire with the owner or [authorized representative or officer of Owner] and to the best of my knowledge and belief the information provided is true, correct and complete. **I therefore recommend opening this account.**

AMERISOURCEBERGEN ASSOCIATE:
Signature_____

_____
Full Name (Print)

_____
Title

_____
Cell Phone Number

